



BOARD OF REGISTERED NURSING
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ONLINE CLINICAL NURSE SPECIALIST APPLICANT IDENTIFICATION FORM

You must complete and submit this form via your online BreZE account, or by mailing to:

Board of Registered Nursing, ATTN: Advanced Practice Unit, P.O. Box 944210, Sacramento, CA 94244-2100.

Print Full Name: _____			
(Last)	(First)	(Middle)	
U.S. Social Security Number or Individual Tax Identification Number: _____			
E-Mail: _____		Date of Birth: _____	
Address: _____			
Name of Clinical Nurse Program: _____			
City, State and Country of Clinical Nurse Specialist Program: _____			
HAVE YOU COMPLETED AND/OR ENCLOSED THE FOLLOWING ITEMS (check all that apply):			
Have you attached a recent 2" x 2" passport type photograph ?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
If applicable, if you are relocating to California as a result of your spouse's/partner's active duty military service, is the supplemental information enclosed?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
If applicable, is supplemental information regarding reporting prior convictions or discipline against licenses enclosed?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<p>I certify under penalty of perjury under the laws of the State of California, that all information provided in connection with this online application for licensure is true, correct and complete. Providing false information or omitting required information is grounds for denial of licensure or license revocation in California.</p> <p>Signature of Applicant: _____</p> <p>Date: _____</p>			<p>Tape Your 2" x 2"</p> <p>Passport Type</p> <p>Photograph Here</p>